STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395016	A. BLDG: 00 B. WING:	03/30/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HANOVER HALL FOR NURSING AND REHABILITATION STATE LICENSE NUMBER: **590102**	**267 FREDERICK STREET HANOVER, PA 17331**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification, State Licensure , Civil Rights survey and two Abbreviated Complaint surveys, completed on March 30, 2023, it was determined that Hanover Hall for Nursing and Rehabilitation was not in compliance with the following requirements of 42 CFR Part 483 Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0558 SS=E		F 0558		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0558 SS=E	Continued from page 1 483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by:	F 0558	1. R21, R53, R71, and R89 were all assessed to ensure call bell had clips attached. R21 and R53 were missing clips. Housekeeping provided clips so call bells could easily attach to bed. R71 and R89s call beds were placed within reach. There were no adverse effects to these residents regarding this concern. 2. House audit completed to ensure all residents had call bell clips. Audit revealed total of 4 residents missing clips. Clips were provided and placed within reach of residents. 3. Housekeeping Director provided education to her team related to ensuring residents have call bell clips. Re-education will be provided to nursing staff also to ensure call bells are within reach of residents. 4. DON/designee will complete call bell audits of 10 residents/week x 4 weeks; then 10 monthly x2 months to ensure call bells are within reach. Audits will be brought to QAPI to ensure compliance and quality improvement.	Completion Date: **05/16/2023** Status: **APPROVED** Date: **04/14/2023**

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F 0558 SS=E	Continued from page 2 Based on observations, clinical record review, and interviews, it was determined that the facility failed to ensure the environment meets the individual needs of each resident by providing adaptive equipment needed to use the call bell system for four of 24 residents reviewed (Resident 21, 53, 71, and 89). Findings include: A facility policy on call bells was requested and none was provided. Review of Resident 21's clinical record revealed diagnoses that included muscle weakness (when your full effort doesn't produce a normal muscle contraction or movement) and peripheral vascular disease (a progressive circulation disorder). Review of Resident 21's care plan on March 27, 2023, revealed a care plan with a focus area of: The Resident is at risk for falls, with a revision date of September 15, 2022; and an intervention of: Be sure the Resident's call light is within reach and	F 0558		

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F 0558 SS=E	Continued from page 3 encourage the Resident to use it for assistance as needed, with a date initiated of September 14, 2022. Observation of Resident 21 on March 27, 2023, at 1:16 PM, revealed Resident 21 lying in bed, and her call bell was lying on the floor on the right side of Resident 21's bed. Review of Resident 53's clinical record revealed diagnoses that included muscle weakness (when your full effort doesn't produce a normal muscle contraction or movement) and peripheral vascular disease (a progressive circulation disorder). Review of Resident 53's care plan on March 28, 2023, revealed a care plan with a focus area of: the Resident is at risk for falls, with a revision date of August 2, 2021; and an intervention of: Be sure the Resident's call light is within reach and encourage the Resident to use it as needed, with a revision date of November 2, 2021.	F 0558		

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F 0558 SS=E	Continued from page 4 Observation of Resident 53 on March 28, 2023, at 9:33 AM, revealed Resident 53 lying in bed, and her call bell was lying on the chair on the right side of the Resident's bed and out of the reach of the Resident. Review of Resident 71's clinical record revealed diagnoses that included muscle weakness (when your full effort doesn't produce a normal muscle contraction or movement) and diabetes mellitus (a disease characterized by high blood glucose). Review of Resident 71's care plan on March 28, 2023, revealed a care plan with a focus area of: the Resident is at risk for falls, with a revision date of June 1, 2021; and an intervention of: Be sure the Resident's call light is within reach and encourage the Resident to use it for assistance as needed, with a revision date of November 2, 2021. Observation of Resident 71 on March 28, 2023, at 9:35 AM, revealed Resident 71 lying in bed and her call bell clipped to the top of her bed above her	F 0558		

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F 0558 SS=E	Continued from page 5 head, out of the reach of the Resident. Review of Resident 89's clinical record revealed diagnoses that included unspecified dementia (decreased ability to think and remember) and anxiety (feeling nervous, restless, or tense). Review of Resident 89's care plan on March 28, 2023, revealed a care plan with a focus area of: the Resident is at risk for falls, with a revision date of March 21, 2022; and an intervention of: Be sure the Resident's call light is within reach and encourage the Resident to use it for assistance as needed, with a date initiated of March 15, 2022. Observation of Resident 89 on March 27, 2023, at 1:32 PM, revealed Resident 89 lying in bed and her call bell was lying on the chair on the right side of Resident 89's bed, out of the reach of Resident 89. Interview with the Nursing Home Administrator on March 30, 2023, at 1:30 AM, revealed that all Residents should have their call bells within their	F 0558		

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F 0558 SS=E	Continued from page 6 reach. Pa. Code 211.12(d)(1) Nursing Services	F 0558		
F 0561 SS=D	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.	F 0561	1. Facility cannot retroactively correct this concern. R44 was able to attend the musical program the following week. 2. An interview with residents will be conducted at the next resident council to ensure no other residents are affected by this concern. 3. Re-education will be provided to nursing staff to ensure they are working with activity staff to meet the activity preferences of residents. 4. TR Director/designee will complete audit of residents' activity attendance versus their preferences to ensure residents are attending their preferred activities. Audit will consist of 10 residents weekly x4 weeks; then 10 monthly x2 months. Audits will be brought to QAPI to ensure compliance and quality improvement.	Completion Date: **05/16/2023** Status: **APPROVED** Date: **04/14/2023**

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F 0561 SS=D	Continued from page 7 This REQUIREMENT is not met as evidenced by:	F 0561		

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F 0561 SS=D	Continued from page 8 Based on clinical record review as well as staff and resident interviews, it was determined that the facility failed to accommodate resident's choice of activity for one of 22 residents reviewed (Resident 44). Findings include: Review of Resident 44's clinical record revealed diagnoses that included congestive heart failure (weakness of the heart that leads to buildup of fluid in the lungs and surrounding body tissues) and abnormalities of gait and mobility. Review of Resident 44's current care plan revealed that he does not ambulate and requires a mechanical lift with two persons assisting for transfers. During an interview with Resident 44 on March 27, 2023 at 11:34 AM, he revealed that he was upset because recently there was a musical program he wanted to attend, but by the time staff got him up and ready, the activity was over. He revealed that he let staff know that he wanted to go to the activity	F 0561		

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F 0561 SS=D	Continued from page 9 prior to the activity. During an interview with Employee 10 (Director of Therapeutic Recreation) on March 30, 2023, at 11:30 AM, he revealed that on March 20, 2023, Resident 44 told him early in the morning that he wished to attend the musical program scheduled for that afternoon at 2:00 PM. Employee 10 revealed that, at that time, he informed nursing staff on Resident 44's unit that he wanted to attend and would need to be up and ready to go. He revealed that activities staff began gathering Residents' for the 2:00 PM activity around 1:30 PM and Resident 44 was not ready. Employee 10 stated that nursing contacted activities at 2:55 PM to inform that Resident 44 was ready, but, by that time, the activity had already concluded. During an interview with the Nursing Home Administrator on March 30, 2023, at 1:27 PM, she revealed the expectation that Resident 44 should have been able to attend the musical program per preference.	F 0561		

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F 0561 SS=D	Continued from page 10 28 Pa 201.18(b)(2) Management 28 Pa Code: 201.29(j) Resident rights	F 0561		
F 0575 SS=E	483.10(g)(5)(i)(ii) Required Postings §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by:	F 0575	1. Facility has update the survey postings with required information. No adverse effects to residents regarding this concern. 2. Additional bulletin boards have been purchased to display required postings on each floor. 3. Education provided to administrative staff regarding regulation for postings. 4. NHA/designee will conduct audits of postings will be conducted on each floor weekly x4 weeks, then monthly for 2 months to ensure appropriate information is posted. Audits will be brought to QAPI to ensure compliance and quality improvement.	Completion Date: **05/16/2023** Status: **APPROVED** Date: **04/14/2023**

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F 0575 SS=E	Continued from page 11 Based on observations and staff interview, it was determined that the facility failed to ensure that informational postings located throughout the facility contained all pertinent state agency and resident advocacy contact information. Findings include: Observation of the informational postings on March 29 2023, at 10:22 AM, revealed the informational postings present at the main facility entrance did not contain the mailing and email addresses of the State Survey Agency, mailing and email addresses of the State Long-Term Care Ombudsman program, mailing and email addresses for the protection and advocacy network agency, contact information (name, phone number, mailing and email addresses) for home and community based service programs, as well as contact information (name, phone number, mailing and email addresses) for the Medicaid Fraud Control unit. It was also observed that required informational postings were not present on second floor nursing units.	F 0575		

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F 0575 SS=E	Continued from page 12 During an interview with the Nursing Home Administrator on March 29, 2023, at 11:35 AM, she revealed that she was in the process of revising the postings and creating a second bulletin board for the second floor nursing units. 28 Pa. Code 201.29(i) Resident rights	F 0575		
F 0577 SS=E	483.10(g)(10)(11) Right to Survey Results/Advocate Agency Info §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and	F 0577	1. Survey book has been moved to an easily accessible location in C2D2 lounge. No adverse effects to residents regarding this concern. 2. House audit completed. Signs posted for survey results at receptionist desk have been removed. 3. The facility will create additional survey inspection binders for each floor. 4. NHA/designee will conduct audits of postings will be conducted on each floor weekly x4 weeks, then monthly for 2 months to ensure appropriate information is posted. Audits will be brought to QAPI to ensure compliance and quality improvement.	Completion Date: **05/16/2023** Status: **APPROVED** Date: **04/14/2023**

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F 0577 SS=E	Continued from page 13 (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by:	F 0577		

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F 0577 SS=E	Continued from page 14 Based on surveyor observation and staff interview, it was determined that the facility failed to ensure that the most recent survey results were posted in a place readily accessible to residents, family members, and legal representatives of residents. Findings include: Observation on March 29, 2023, at 9:20 AM, revealed signage posted on a bulletin board at the main facility entrance indicating that the survey results book was located at reception. During an immediate interview with Employee 11 (Receptionist) she revealed that she knew where the book was kept, and went to a side room to retrieve it. The side room was behind the reception area and was not freely accessible to residents or their representatives. Consequently, they would be required to ask for the book in order to see it. During an interview with the Nursing Home Administrator on March 29, 2023, at 11:35 AM,	F 0577		

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F 0577 SS=E	Continued from page 15 she revealed that, in the past, the survey book was available in the lounge areas on upstairs and downstairs nursing units, and that she did not know why or when it had been moved to its current location. 28 Pa. Code 201.18(b)(2) Management 28 Pa. Code 201.29(a) Resident rights	F 0577		
F 0578 SS=E		F 0578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395016	A. BLDG: 00 B. WING:	03/30/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HANOVER HALL FOR NURSING AND REHABILITATION STATE LICENSE NUMBER: **590102**	**267 FREDERICK STREET HANOVER, PA 17331**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0578 SS=E	Continued from page 16 483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance	F 0578	1. R33, R59, R77, and R91 have been provided information on formulating an advanced directive. No adverse effects to residents from this concern. 2. House audit will be conducted to ensure residents have been provided an opportunity to formulate an advanced directive. 3. Re-education will be provided to Social Worker on the policy for advanced directives and the need for ongoing follow up. 4. NHA/designee will complete weekly audit of up to 10 residents (based on that weeks care plan schedule); then 10 residents per month x2 months to ensure SW documentation aligns with policy for offering/reviewing advanced directive. Audits will be brought to QAPI to ensure compliance and quality improvement.	Completion Date: **05/16/2023** Status: **APPROVED** Date: **04/14/2023**

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F 0578 SS=E	Continued from page 17 directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by:	F 0578		

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F 0578 SS=E	Continued from page 18 Based on facility policy review, clinical record reviews, interviews, and resident rights, it was determined that the facility failed to offer the option to formulate an advance directive and provided no documentation pertaining to resident's choices for advance directives, or documenting how the resident was informed of his/her right to develop a living will or advance directive for four of 20 resident records reviewed (Residents 33, 59, 77, and 91). Findings include: Review of the facility's policy, titled "Advance Directives," revised December 2016, reads, in part, "Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so." Also, "Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives."	F 0578		

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F 0578 SS=E	Continued from page 19 The policy continues "The Interdisciplinary Team will review annually with the resident his or her advance directive to ensure that such directives are still the wishes of the resident." An Advance Directive is defined as "A written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor." The directive is also defined as "A living will, personal directive, advance directive, medical directive or advance decision, is a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity" Review of Resident 33's clinical record revealed an admission date of March 24, 2021. Continued review of Resident 33's clinical record	F 0578		

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F 0578 SS=E	Continued from page 20 revealed no advance directive document, nor any documentation of staff review on an annual basis. Interview with Employee 2 (Director of Admissions) on March 29, 2023, at 10:30 AM, revealed that Resident 59 was admitted September 18, 2020, and didn't have an electronic form noting whether an advanced directive was available, or that Resident 59 was offered assistance with formulating an advanced directive. It was revealed that, if Resident 59 had an advanced directive, it would be on her "hard" chart, as it was not in the electronic record. Review of Resident 59's "hard chart" and electronic clinical record on March 29, 2023, failed to reveal an advanced directive, nor evidence that Resident 59 was offered an opportunity to create an advanced directive. During an interview with the Nursing Home Administrator (NHA) on March 29, 2023, at 11:30 AM, it was revealed that code status is reviewed quarterly during the care plan meeting. It was also	F 0578		

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F 0578 SS=E	Continued from page 21 revealed that for residents admitted prior to November 2021, when the facility was sold, there may not be documentation that a resident was offered assistance to formulate an advanced directive. It was requested that the facility provide documentation that Resident 59 was offered assistance to formulate an advanced directive if an advanced directive wasn't of file; no further information was provided. Review of Resident 77's clinical record revealed an admission date of January 6, 2021. Continued review of Resident 77's clinical record revealed no advance directive document, nor any documentation of staff review on an annual basis. Review of Resident 91's clinical record revealed an admission date of June 1, 2022. Continued review of Resident 91's clinical record	F 0578		

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F 0578 SS=E	Continued from page 22 revealed no documentation of the facility offering the Resident or Representative the opportunity to formulate an advance directive. An interview with the NHA on March 30, 2023, at 11:35 AM, revealed it is the responsibility of the Social Services Director to follow-up on the facility's advance directive policy and stated she "would suspect no follow up" by staff in regards to the resident's right to formulate an advance directive at admision and an ongoing basis. 28 Pa. Code 211.5 Clinical records 28 Pa. Code 211.10 (a) Resident care policies	F 0578		
F 0582 SS=D		F 0582		

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F 0582 SS=D	Continued from page 23 483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation	F 0582	1. Facility cannot retroactively correct this concern for R88 and R92. No adverse effects to residents as a result of this concern. 2. An audited was completed at the beginning of March and revealed a concern with providing SNFABNs as required. Plan of correction was implemented at this time and education provided to social worker. 3. Re-education will be provided to Social Worker on requirements for NOMNC and SNF ABNs. 4. NHA/designee will complete a weekly audit of all Part A cut letters x4 weeks, then up to 5 monthly x2 months. Audits will be brought to QAPI to ensure compliance and quality improvement.	Completion Date: **05/16/2023** Status: **APPROVED** Date: **04/14/2023**

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F 0582 SS=D	Continued from page 24 of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by:	F 0582		

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F 0582 SS=D	Continued from page 25 Based on clinical record review, document review, and staff interview, it was determined that the facility failed to ensure each resident is notified of services available in the facility and charges for those services not covered under Medicare for two of three residents reviewed (Residents 88 and 92). Findings Include: Review of 88's clinical record revealed diagnoses that included anxiety (intense, excessive, and persistent worry and fear about everyday situations) and anemia (a condition in which the blood doesn't have enough healthy red blood cells) Review of Resident 88's payor source information revealed a last covered day of Medicare A services on October 14, 2022. Review of documentation provided by Employee 3 (Social Services Director), revealed Resident 88 was not issued the required the Skilled Nursing Facility-Advance Beneficiary Notice of	F 0582		

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F 0582 SS=D	Continued from page 26 Non-Coverage form (SNF-ABN-a form detailing the facility charges for services not covered by Medicare) at the conclusion of the covered Medicare services. Review of Resident 92's clinical record revealed diagnoses that included dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain) and hypertension (elevated blood pressure). Review of Resident 92's payor source information revealed a last covered day of Medicare A services on September 13, 2022. Review of documentation provided by Employee 3, revealed Resident 92 was not issued the required SNF-ABN form at the conclusion of the covered Medicare services.	F 0582		

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F 0582 SS=D	Continued from page 27 An interview with the Nursing Home Administrator, on March 28, 2023, at 1:06 PM, revealed Employee 3 was not providing residents the required SNF-ABN form and the facility has initiated a plan to issue the form to its residents going forward. 28 Pa. Code 201.14 (a) Responsibility of licensee	F 0582		
F 0585 SS=E	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.	F 0585	1. No adverse effects to any residents as a result of this concern. 2. Facility will place grievance forms at bulletin boards and provide a location to file an anonymous grievance. 3. Residents will be informed of new placement of grievance forms and their ability to file an anonymous grievance. 4. NHA/designee will conduct audits of bulletin boards on each floor weekly x4 weeks, then monthly for 2 months to ensure residents/families have easy access to filing anonymous grievance. Audits will be brought to QAPI to ensure compliance and quality improvement.	Completion Date: **05/16/2023** Status: **APPROVED** Date: **04/14/2023**

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F 0585 SS=E	Continued from page 28 §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;	F 0585		

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F 0585 SS=E	Continued from page 29 (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by:	F 0585		

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F 0585 SS=E	Continued from page 30	F 0585		

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F 0585 SS=E	Continued from page 31 Based on observation, facility policy review, and staff interview, it was determined that the facility failed to provide residents access to grievance forms in a manner that honors the right to file grievances anonymously. Findings include: Review of facility policy, titled "Grievance Policy," undated, revealed, "The facility will make information on how to file a grievance or complaint available to the resident by notifying the resident individually or with prominent postings throughout the facility to include: The right to file a grievance in writing or orally (spoken); The right to file a grievance anonymously." Observation on March 28, 2023, at 9:55 AM, failed to reveal that grievance/concern forms were readily available to residents or resident representatives. During an interview with Employee 9 (Licensed	F 0585		

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	395016	A. BLDG: 00 B. WING:	03/30/2023

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F 0585 SS=E	Continued from page 32 Practical Nurse) on March 28, 2023, at 9:56 AM, she revealed that grievance forms are kept behind each nursing desk. Residents or family members can ask and staff will provide the form. The forms could then be handed back in and would be brought to the social service office. During an interview with Employee 3 (Social Services Director) on March 28, 2023, at 10:13 AM, she confirmed that grievance forms are kept at the nursing stations and in the social services office, and that residents can ask and get a form. During an interview with the Nursing Home Administrator on March 28, 2023 at 10:51 AM, she revealed that, at one point, the grievance information and forms were located on the wall near each nursing stations; however, the bulletin boards were updated and that information was removed. She also revealed that the plan is to purchase bulletin boards for each nursing station and to post the grievance information, provide access to the grievance forms, and provide a place to submit the	F 0585		

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F 0585 SS=E	Continued from page 33 forms anonymously. Finally, she revealed the expectation that the grievance forms should be readily available, and a process should be in place to submit a grievance anonymously. 28 Pa. Code 201.18(b)(2) Management 28 Pa. Code 201.29(a)(i) Resident rights	F 0585		
F 0600 SS=D	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 0600	1. No residents were negatively affected by this concern. Employee #12s criminal background check was completed and did not reveal any concerns. 2. Facility completed audit of all employee files to ensure all current employees have a criminal background check completed. 3. Re-education will be provided to HR Director regarding completion of background check with the onboarding process. 4. NHA/designee will audit all new employees monthly x3 months to ensure all criminal background checks are completed. Audits will be brought to QAPI to ensure compliance and quality improvement.	Completion Date: **05/16/2023** Status: **APPROVED** Date: **04/14/2023**

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F 0600 SS=D	Continued from page 34 Based on review of facility policy, employee personnel files, and staff interviews, it was determined that the facility failed to complete a background review to ensure the facility doesn't employ an individual that has been convicted of abuse, neglect, or mistreatment of another individual for one of five employee files reviewed (Employee 12). Findings include: Review of the facility policy, titled "Abuse Policy", revised November 28, 2020, read, in part, facility conducts employee background checks and will not knowingly employ any individual who has been convicted of abusing, neglecting, or mistreating individuals. Review of Employee 12's (Registered Nurse) personnel file it was documented that she was rehired on January 26, 2023, and her Pennsylvania State Police Criminal Record Check disseminated (completed) on March 27, 2023.	F 0600		

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F 0600 SS=D	Continued from page 35 Interview with Nursing Home Administrator on March 28, 2023, at 1:00 PM, revealed that Employee 12 resigned, due to not wanting to follow COVID-19 policy regarding use of N95 face mask. Because she was designated as a rehire, she went through an abbreviated on boarding process. It was revealed that her Criminal Record Check was not completed at time of rehire; and it should have been. During an interview with Employee 14 (Human Resource Director) on March 29, 2023, at 10:00 AM, revealed that Employee 12 was initially hired September 19, 2009, resigned August 1, 2022, and was rehired January 26, 2023. It was also revealed that the Pennsylvania State Police Criminal Record Check should have been completed upon rehire. 28 Pa. code 201.14(a) Responsibility of Licensee 28 Pa. code 201.18(b)(1) Management	F 0600		
F 0623 SS=D		F 0623		

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F 0623 SS=D	Continued from page 36 483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)	F 0623	1. Facility cannot retroactively correct this concern for R55. No adverse effects to R55 as a result of this concern. 2. House Audit was completed in December and revealed a process breakdown with the delivery of transfer notices. Facility corrected this concern at that time. 3. Education provided to Social Worker and Admissions Coordinator on regulatory requirement with transfers out of the facility. Social Worker will begin to email the transfer letters to the Office of LTC Ombudsman rather than fax notifications. 4. NHA/designee will complete audit of all transfers out of the facility to ensure notices are sent x2 months. Audits will be brought to QAPI to ensure compliance and quality improvement.	Completion Date: **05/16/2023** Status: **APPROVED** Date: **04/14/2023**

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F 0623 SS=D	Continued from page 37 (1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and	F 0623		

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F 0623 SS=D	Continued from page 38 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by:	F 0623		

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F 0623 SS=D	Continued from page 39 Based on clinical record review and staff interview, it was determined that the facility failed to notify the resident or resident's representative and the Office of the State Long-Term Care Ombudsman of resident transfers, in writing, and with the required transfer information for one of two residents reviewed for hospitalizations (Resident 55). Findings include: Review of Resident 55's clinical record revealed diagnoses that included anemia (condition that develops when the blood lacks enough healthy red blood cells) and pressure ulcer of left buttock (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result or pressure, or pressure in combination with shear and/or friction). Further review revealed that Resident 55 was transferred to the hospital following a change in condition on September 12, 2022, and was subsequently admitted. An additional review of Resident 55's clinical record	F 0623		

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F 0623 SS=D	Continued from page 40 failed to reveal that written notification was provided to the Resident or her Representative regarding hers transfer to the hospital, which included the following required contents: reason for transfer, effective date of the transfer, location to which the Resident was transferred, a statement of the Resident's appeal rights, and contact information for the Office of the State Long-Term Care Ombudsman. During an interview with the Nursing Home Administrator on March 29, 2023, at 11:27 AM, she revealed that no notice of transfer was provided to the Resident, her Representative, or Office of the State Long-Term Care Ombudsman. 28 Pa. Code 201.14(a) Responsibility of licensee	F 0623		
F 0625 SS=D		F 0625		

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F 0625 SS=D	Continued from page 41 483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:	F 0625	1. Facility cannot retroactively correct this concern for R55. No adverse effects to R55 as a result of this concern. 2. House Audit was completed in December and revealed a process breakdown with the delivery of bed-hold notices. Facility corrected this concern at that time. 3. Education provided to Social Worker and Admissions Coordinator on regulatory requirement with the bed-hold notifications. 4. NHA/designee will complete audit of all transfers out of the facility to ensure bed-hold notices were sent x2 months. Audits will be brought to QAPI to ensure compliance and quality improvement.	Completion Date: **05/16/2023** Status: **APPROVED** Date: **04/14/2023**

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F 0625 SS=D	Continued from page 42	F 0625		

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F 0625 SS=D	Continued from page 43 Based on clinical record review and staff interview, it was determined that the facility failed to ensure the resident and/or the resident's representative were provided the bed-hold notice upon transfer for one of two residents reviewed for hospitalizations (Resident 55). Findings Include: Review of Resident 55's clinical record revealed diagnoses that included anemia (condition that develops when the blood lacks enough healthy red blood cells) and pressure ulcer of left buttock (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result or pressure, or pressure in combination with shear and/or friction). Further review revealed that Resident 55 was transferred to the hospital following a change in condition on September 12, 2022, and was subsequently admitted. Further review of Resident 55's clinical record revealed no documentation of notification to the	F 0625		

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F 0625 SS=D	Continued from page 44 Resident and/or Resident Representative regarding the facility's bed-hold policy at the time of Resident's transfer to the hospital. During an interview with the Nursing Home Administrator on March 29, 2023, at 11:27 AM, she revealed that no notice of bed-hold was provided to the Resident or her Representative at the time of her hospitalization. 28 Pa. Code 201.14(a) Responsibility of license	F 0625		
F 0657 SS=D		F 0657		

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F 0657 SS=D	Continued from page 45 483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 0657	1. R91s care plan was revised to reflect current discharge plan. The missing code status care plan was identified on 3/28 and updated at that time. There were no adverse effects to R91 as a result of this concern. 2. House audit will be completed on discharge plans and code status to ensure both are care planned. 3. Re-education will be provided to the Inter-disciplinary care plan team to ensure care plans are updated with any changes, and, at minimum, quarterly. 4. RNAC/designee will complete audit of 5 residents weekly x4 weeks, and 10 monthly x2 months to ensure any changes are care planned accordingly. Audits will be brought to QAPI to ensure compliance and quality improvement.	Completion Date: **05/16/2023** Status: **APPROVED** Date: **04/14/2023**

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F 0657 SS=D	Continued from page 46 Based on clinical record review and resident and staff interview, it was determined that the facility failed to ensure the timeliness of the resident's person-centered comprehensive plan of care is reviewed and revised by the interdisciplinary team for one of 20 residents reviewed (Resident 91). Findings Include: Review of Resident 91's clinical record revealed diagnoses that included muscle weakness and a history of falling. An interview with Resident 91, on March 28, 2023, at 9:49 AM, revealed a desire to return to her apartment in the community and an understanding that she no longer is in need of skilled nursing facility care. Review of Resident 91's interdisciplinary plan of care revealed none related to discharge planning and Resident 91's short-term or long-term care goals.	F 0657		

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F 0657 SS=D	Continued from page 47 An interview with Employee 3 (Social Services Director) and the Nursing Home Administrator (NHA), on March 29, 2023, at 1:36 PM, confirmed Resident 91 is considered a long-term Resident and confirmed no discharge planning goals were documented in the interdisciplinary plan of care. A subsequent interview with Employee 3 revealed a care plan related to Resident 91's needs and goals regarding discharge planning was immediately initiated. Review of Resident 91's March 2023, physician orders summary report revealed an order that read "CPR (Cardiopulmonary Resuscitation)" dated February 14, 2023. CPR is an emergency procedure consisting of chest compressions often combined with artificial ventilation in an effort to manually preserve intact brain function until further measures are taken to restore spontaneous blood circulation and breathing	F 0657		

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F 0657 SS=D	Continued from page 48 in a person who is in cardiac arrest. Continued review of Resident 91's interdisciplinary plan of care indicated the Resident's desire to be a DNR (Do Not Resuscitate) code status, with the most recent revision dated on January 31, 2023. DNR is a medical order, written or oral depending on country, indicating that a person should not receive cardiopulmonary resuscitation if that person's heart stops beating. An interview with Employee 3 on March 30, 2023, at 10:44 AM, revealed the interdisciplinary plan of care and the physcian orders related to resident 91's code status were not in agreement. An interview with the NHA on March 30, 2023, at 10:56 AM, confirmed there was a delay in updating Resident 91's preferred code status on the interdisciplinary plan of care. 28 Pa. Code 211.11 (d) Resident care plan	F 0657		

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F 0657 SS=D	Continued from page 49 28 Pa. Code 211.12 (d) (5) Nursing services 28 Pa. Code 211.15 (f) Clinical records	F 0657		
F 0684 SS=E		F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0684 SS=E	Continued from page 50 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	1. Facility cannot retroactively correct this concern. R39, R55, and R246 did not suffer any adverse effects from this concern. 2. Facility will conduct audit of MARS and TARS for last 30 days to ensure no other residents were affected by this concern. Facility will complete audit of falls with neuro-checks the last 30 days to ensure no others were affected. 3. Re-education will be provided to nursing staff on order entry related to wound orders; falls management/neuro-checks, and ensuring they are documenting supplements as ordered. Process for stocking gelatin supplements revised for easier access of this item to the nursing staff. Clinical meeting process reviewed with clinical team to ensure missing documentation and any neuro-checks are followed up with immediately. 4. DON/designee will audit 10 residents weekly for missing documentation in MARS/TARS; then 10 monthly x2 months. DON/designee will conduct audits of	Completion Date: **05/16/2023** Status: **APPROVED** Date: **04/14/2023**

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F 0684 SS=E	Continued from page 51	F 0684	all falls with neuro-checks x1 month; then 5 falls monthly x 2 months to ensure all neuro-checks are completed. Audits will be brought to QAPI to ensure compliance and quality improvement.	

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F 0684 SS=E	Continued from page 52 Based on review of policy review, clinical record review, facility reported incident, and staff interview, it was determined that the facility failed to ensure care and services are provided in accordance with professional standards of practice to meet each resident's physical, mental, and psychosocial needs for three of 23 residents reviewed (Residents 39, 55, and 246) Findings include: Review of facility policy, titled "Dressings, Dry/Clean"; with a revision date of September 2013, revealed in the section labeled "Documentation", that upon completing a dressing change, the person completing the dressing change should document the date and time the dressing was changed, wound appearance, name and title of the individual changing the dressing, and type of dressing and wound care given. Also, review of the section of the policy "Reporting", revealed that employees are to notify the supervisor if the Resident refuses a dressing change.	F 0684		

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F 0684 SS=E	Continued from page 53 Review of Resident 39's clinical record revealed diagnosis of type 2 diabetes (a chronic condition that affects the way the body processes blood sugar) and chronic kidney disease (longstanding disease of the kidneys leading to renal failure). Review of Resident 39's discontinued physician's orders revealed a physician's order with a start date of February 9, 2023, to cleanse ulcers on the Resident's right and left buttocks and apply a foam dressing on Tuesdays, Thursdays, Saturdays, and as needed. The order was discontinued on February 14, 2023. Review of Resident 39's Treatment Administration Record (TAR) for the month of February 2023 revealed that Resident 39 had her dressing changed on Tuesdays, Thursdays, and Saturdays from the time the order was created until it was discontinued. Further review of Resident 39's discontinued physician's orders revealed a physician's order with	F 0684		

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F 0684 SS=E	Continued from page 54 a start date of February 14, 2023, to apply 4-in-1 cream (medicated cream used to in dressings to relieve pain and prevent infection) to MASD (moisture associated skin damage) on the Resident's right and left buttocks daily and as needed. The order was active from February 14, 2023, until it was discontinued on March 22, 2023. Review of Resident 39's Treatment Administration Record (TAR) for the months of February 2023 and March 2023 failed to reveal that Resident 39 had her dressing changed as ordered from February 14, 2023, until March 22, 2023. Further review of Resident 39's current physician's orders revealed a physician's order with a start date of March 22, 2023, to apply 4-in-1 cream to MASD on the Resident's right and left buttocks daily and as needed every day shift. The order was active starting March 22, 2023, and it still active. Review of Resident 39's Treatment Administration Record (TAR) for the month of March 2023	F 0684		

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F 0684 SS=E	Continued from page 55 revealed that Resident 39 had her dressing changed daily as ordered from March 22, 2023, until today, March 30, 2023. Interview with the Director of Nursing (DON), on March 30, 2023, at 1:05 PM, revealed that the facility was unable to find any documentation that would show that the dressing was changed daily, per physician order from February 14, 2023, until March 22, 2023. The DON also revealed that the order was entered incorrectly and did not alert the nursing staff to complete the dressing. The mistake was found on March 22, 2023, and that is why the new order was created to correct the problem. Review of Resident 55's clinical record revealed diagnoses that included anemia (condition that develops when the blood lacks enough healthy red blood cells) and pressure ulcer of left buttock (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result or pressure, or pressure in combination with shear and/or friction).	F 0684		

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F 0684 SS=E	Continued from page 56 Review of Resident 55's current physician orders revealed an order for Gelatein supplement twice a day, effective December 13, 2022. Review of dietician progress note dated March 16, 2023, revealed that Gelatein supplement (protein supplement) was ordered to aid in wound healing. Review of nursing progress notes dated March 23-27 and 29, 2023, revealed Gelatein was not provided to Resident 55 because it was unavailable. During an interview with the DON on March 30, 2023, at 12:35 PM, she revealed that Gelatein was available in the facility on the aforementioned dates, that nursing was aware of where it was stored, and that they should have asked a supervisor for assistance in locating it. Review of facility policy, titled "Neurological Evaluation," revised July 2019, revealed, that neurological evaluations should be completed	F 0684		

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F 0684 SS=E	Continued from page 57 following an unwitnessed fall, and that the checks should be completed at the following intervals: every 15 minutes x one hour, every 30 minutes x 4 hours, every hour x 2 hours, then every shift x 72 hours unless otherwise specified by physician order. Review of Resident 246's clinical record revealed diagnoses that included metabolic encephalopathy (abnormalities of the water, electrolytes, vitamins, and other chemicals that adversely affect brain function) and history of falling. Review of incident report dated March 25, 2023, revealed that Resident 246 experienced an unwitnessed fall this date at 8:18 PM. Review of neurological evaluation flow record for Resident 246 revealed that no neurological evaluation checks were documented between 2:05 AM on March 26, 2023, and the 7 AM - 3 PM shift on March 27, 2023. During an interview with the DON on March 30,	F 0684		

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F 0684 SS=E	Continued from page 58 2023, at 2:00 PM, she had no additional documentation that the neurological checks were completed or refused during that timeframe. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.18(b)(3)(e)(1) Management 28 Pa. Code 211.12(c)(d)(2) Nursing services 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0684		
F 0688 SS=D		F 0688		

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F 0688 SS=D	Continued from page 59 483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:	F 0688	1. Facility cannot retroactively correct this concern. R35 did not suffer any adverse effects from this concern. 2. Facility will conduct audits of restorative programs for last 30 days to ensure no other residents were affected. 3. Re-education will be provided to nursing staff regarding accurate documentation with restorative programs. 4. DON/designee will audit restorative programs of 10 residents weekly x4 weeks, then 10 monthly x2 months to ensure restorative programs are being completed. Audits will be brought to QAPI to ensure compliance and quality improvement.	Completion Date: **05/16/2023** Status: **APPROVED** Date: **04/14/2023**

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F 0688 SS=D	Continued from page 60 Based on clinical record and staff interview, it was determined that the facility failed to implement a restorative ambulation program, per the resident's plan of care, for one of 22 residents reviewed (Resident 35). Findings include: Review of Resident 35's clinical record revealed diagnoses that included history of poliomyelitis (viral infection causing nerve injury, which leads to partial or full paralysis) and vascular dementia (condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain that causes problems with reasoning, planning, judgment, and memory). Review of Resident 35's current care plan revealed the following focus area: "Resident would benefit from a restorative ADL [Activities of Daily Living] program" with a goal to perform body bathing and grooming after setup while supine in bed, last revised August 2, 2021.	F 0688		

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F 0688 SS=D	Continued from page 61 Review of Resident 35's current physician orders revealed an order to verify restoratives (for ADL/bathing) are offered, attempted, completed, and documented every day and evening shift, effective June 6, 2022. Review of Resident 35's restorative ambulation documentation for February 28, 2023, through March 29, 2023, revealed three days when restorative ambulation was not documented as having been completed twice daily. No refusals were noted. During an interview with the Director of Nursing on March 30, 2023, at 10:43 AM, she confirmed it was ordered and should have been done twice per day. She revealed she had no additional information on the missing documentation. 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0688		
F 0730 SS=E		F 0730		

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F 0730 SS=E	Continued from page 62 483.35(d)(7) Nurse Aide Peform Review-12 hr/yr In-Service §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by:	F 0730	1. Employees 5, 6, 7, and 8 have since had performance reviews completed. 2. House audit completed in November revealed performance evaluations were not being completed as scheduled. Facility has since provided education to department managers and implemented a process for performance reviews. 3. Re-education will be provided to department heads to ensure employee reviews are completed annual with the anniversary of their date of hire. 4. HR/designee will complete random audits of 5 employees monthly x 3 months to ensure performance evaluations are being completed. Audits will be brought to QAPI to ensure compliance and quality improvement.	Completion Date: **05/16/2023** Status: **APPROVED** Date: **04/14/2023**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0730 SS=E	Continued from page 63 Based on document review and staff interview, it was determined that the facility failed to complete a performance review of every nurse aide at least once every 12 months for four of five nurse aide performance evaluations reviewed (Employees 5, 6, 7, and 8). Findings Include: Review of the facility's list of nurse aide staff revealed Employee 5 with a hire date in 2004; Employee 6 with a hire date in 2012; Employee 7 with a hire date in 2017; and Employee 8 with a hire date in 2019. Requests for the most recent yearly performance reviews revealed Employees 5, 6, 7, and 8 were last completed in 2020. An interview with the Nursing Home Administrator, on March 29, 2023, at 2:28 PM, confirmed the nurse aide performance evaluations had not been completed in the past year on the aforementioned	F 0730		

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F 0730 SS=E	Continued from page 64 nurse aides. 28 Pa. Code 201.19 Personnel policies and procedures	F 0730		
F 0791 SS=D	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a	F 0791	1. R67 was seen by dentist 4/4/23. No adverse effects to resident as a result of this concern 2. Facility will complete a review of current residents to ensure dental services are being provided as needed. 3. Process for referrals to in-house dental provider was reviewed. Education to provider regarding cited concern. Education to social worker will be conducted to ensure SW understands referral process. 4. SW/designee will conduct audits of dental referrals made to provider of up to 10 residents per month x3 months to ensure all referrals are followed up with appropriately. Audits will be brought to QAPI to ensure compliance and quality improvement.	Completion Date: **05/16/2023** Status: **APPROVED** Date: **04/14/2023**

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F 0791 SS=D	Continued from page 65 referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by:	F 0791		

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F 0791 SS=D	Continued from page 66 Based on clinical record review and resident and staff interview, it was determined that the facility failed to assist residents in obtaining routine dental care for one of 20 residents reviewed (Resident 67). Findings Include: Review of Resident 67's clinical record revealed diagnoses that included muscle weakness and a history of falling. An interview with Resident 67 on March 27, 2023, at 10:44 AM, revealed concerns with eating his meals due to a lack of the bottom row of teeth. An interview with the Nursing Home Administrator and Employee 3 (Social Services Director), on March 29, 2023, at 1:20 PM, revealed Resident 67 had been scheduled to see the mobile dental provider on March 16, 2023; however, he was "not seen" and he was "missed" on the day the dentist visited the facility. The interview also revealed the facility plans to follow-up and reschedule Resident	F 0791		

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F 0791 SS=D	Continued from page 67 67's dentist visit. 28 Pa. Code 211.5 (a) Dental services	F 0791		
F 0803 SS=E	483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal	F 0803	1. Facility cannot retroactively correct this concern. No residents were negatively effected by this concern. Stuffed green peppers have been removed from the menu. 2. Dietitian will review current menu cycle to ensure nutritional needs are being met. 3. Each new cycle menu will be reviewed by dietitian to ensure it meets nutritional guidelines. Adjustments/substitutions will be made as needed. 4. Dietitian/designee will audit 5 meals/week x 4 weeks, and then 10 meals/month x2 months to ensure daily nutritional needs are being met. Audits will be brought to QAPI to ensure compliance and quality improvement.	Completion Date: **05/16/2023** Status: **APPROVED** Date: **04/14/2023**

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F 0803 SS=E	Continued from page 68 dietary choices. This REQUIREMENT is not met as evidenced by:	F 0803		

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F 0803 SS=E	Continued from page 69 Based on observations, facility documentation, policy review, product label, United States Department of Agriculture Nutrient data base, and resident and staff interviews, it was determined that the facility failed to provide a nutritionally adequate menu for one of one meals observed (March 28, 2023, lunch meal). Findings include: Interviews with residents during the initial pool process revealed concerns with the quality of the food. Review of the facility diet manual policy, not dated, read, in part, a regular diet provides approximately 2,200 to 2,400 calories, and 80-100 grams of protein. The policy also included a chart documenting the portions for a regular diet during the lunch meal, which read, in part, three ounce portion of meat or an eight ounce portion of a casserole, 1/2 cup starch, 1/2 cup vegetable, and 1/2 cup fruit.	F 0803		

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F 0803 SS=E	Continued from page 70 Review of the facility menu and diet spreadsheet (guide as to portion sizes and food items for all diets) for the lunch meal on March 28, 2023, read, in part, one stuffed green pepper, 1/2 cup cauliflower, one dinner roll, and 1/2 cup diced pears. Meal service observation on March 28, 2023, during the noon meal, revealed some residents were served cauliflower and others were served carrots; some residents were served pears and others were served peaches; and the portion of stuffed pepper was a half of pepper with a mounded scoop of filling. The stuffed pepper was observed to be smaller than eight ounces. Interview on March 28, 2023, at 12:35 PM, surveyor revealed to Employee 13 that the portion of the stuffed pepper looked to be less than the required serving size. Employee 13 revealed that the products available for purchase are regulated by the facility's corporate office. It was also revealed that	F 0803		

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F 0803 SS=E	Continued from page 71 budgetary constraints set by the facility's corporate office limit the amount of food that can be purchased. The stuffed pepper was a pre-portioned frozen premade product, that was heated and served. It was revealed that there wasn't enough cauliflower and pears to serve the entire facility; once those items were utilized the remaining residents were served carrots and peaches. Review of the stuffed pepper product specifications read, in part, a stuffed green bell pepper filled with seasoned ground beef, onions, rice, and topped with a tomato sauce. Review of the nutritional fact sheet read, in part, one pepper half weighed 6.91 ounces and contained 7 grams of protein. According to the United States Department of Agriculture Nutrient data base, three ounces of 90% lean, 10% fat ground beef contains 16.8 grams of protein. The facility failed to provide an ample portion of meat/protein at the noon meal on March 28, 2023.	F 0803		

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F 0803 SS=E	Continued from page 72 Interview with Employee 13 on March 29, 2023, 12:45 PM, revealed that sufficient cauliflower and pears were ordered, but the amount ordered wasn't delivered. Interview with the Nursing Home Administrator on March 29, 2023, at 2:11 PM, revealed that the expectation is the meal planning guide in the diet manual would be followed, and residents would be served the appropriate potions and planned menu items. Pa code 211.6(a)(b) - Dietary Services	F 0803		
F 0804 SS=E		F 0804		

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F 0804 SS=E	Continued from page 73 483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by:	F 0804	1. Facility cannot retroactively correct this concern. No residents were negatively effected by this concern. 2. Facility will conduct an interview with residents at the next Food Committee to determine if other residents have expressed concerns with food temps. 3. Re-education will be completed with dietary services staff to ensure they are aware of policy and appropriate temperatures for both hot and cold foods. 4. DSM/designee will conduct test tray audits for 5 meals weekly x4 weeks; then 10 monthly x2 months to ensure appropriate temperatures. Audits will be brought to QAPI to ensure compliance and quality improvement.	Completion Date: **05/16/2023** Status: **APPROVED** Date: **04/14/2023**

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F 0804 SS=E	Continued from page 74 Based on observation, review of facility policy, and interviews, it was determined that the facility failed to provide food and beverage that are palatable and at a safe and appetizing temperature for one of one meal observed on the 100 hallway. Findings include: Interviews with residents during the initial pool process revealed concerns with the quality and temperature of the food. Review of facility policy, titled "Serving of Food at Point of Service", revised December 9, 2021, read, in part, all hot food shall be held during service at or above 135 degrees Fahrenheit, and all cold food shall be held during service at or below 41 degrees Fahrenheit. Review of the facility form "Culinary and Nutrition Test Tray", no date, read, in part, point of service temperatures: hot entree greater than 135 degrees Fahrenheit, cold entree/dessert less than 41 degrees	F 0804		

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F 0804 SS=E	Continued from page 75 Fahrenheit, and hot beverage greater than 135 degrees Fahrenheit. Test tray temps taken on March 28, 2023, at 12:29 PM, by Employee 13 (Director of Food Service) revealed the following: stuffed bell pepper: 150 degrees Fahrenheit carrots: 130 degrees Fahrenheit dinner roll: room temp peaches: 50 degrees Fahrenheit yogurt: 50 degrees Fahrenheit , should be colder temperature coffee: 126 degrees Fahrenheit , should be warmer temperature cranberry juice: 42 degrees Fahrenheit Interview with Employee 13 on March 28, 2023, at 12:35 PM, revealed that test trays are completed when there are noted concerns with meals, and there haven't been concerns voiced with meals recently. It was also noted that the yogurt is stored in a refrigerator on tray line during meal service. It was also revealed that residents could request their	F 0804		

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F 0804 SS=E	Continued from page 76 coffee to heated in the microwave if they preferred their coffee to be hotter. During an interview on March 29, 2023, at 11:00 AM, the Nursing Home Administrator was informed of the concerns with the test tray; and it was revealed that food and beverages should be served at appropriate temperatures. 28 Pa code 211.6(b)(d) - Dietary Services	F 0804		
F 0809 SS=E		F 0809		

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F 0809 SS=E	Continued from page 77 483.60(f)(1)-(3) Frequency of Meals/Snacks at Bedtime §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by:	F 0809	1. R83 was not negatively affected by this concern. 2. Facility will conduct interview with residents at next Food Committee to determine if other residents have been affected by this concern. 3. Education will be provided to nursing staff on the importance of offering and documenting nourishing HS snack. Education will be provided to dietary staff regarding facility approved snack list, to include those on regular and altered diets. Additional snacks with added protein and fruit will be stocked in pantries and available to residents for evening snack. 4. DON/designee will conduct audits of HS snacks of 5 residents weekly x4 weeks; then 10 residents monthly x2 months to ensure evening snacks are being offered. Audits will be brought to QAPI to ensure compliance and quality improvement.	Completion Date: **05/16/2023** Status: **APPROVED** Date: **04/14/2023**

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F 0809 SS=E	Continued from page 78 Based on review of facility documentation and staff and resident interviews, it was determined the facility failed to ensure the provision of a nourishing evening snack when more than 14 hours elapsed from the evening meal to breakfast the following day. Findings include: A review of the facility's cart delivery times revealed 15 hours between dinner and breakfast. During an interview with Resident 83 on March 28, 2023, at 10:22 AM, he revealed that he was not always offered an evening snack, but that he wishes he was. During an interview with Employee 14 (Nurse Aide) on March 29, 2023, at 9:30 AM, she revealed that, at times, there are insufficient supplies of snack. She revealed that snacks are supposed to be stocked on the unit in the evening, but sometimes this does not happen. She also revealed that, consequently, staff have felt the need to purchase snacks and bring	F 0809		

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F 0809 SS=E	Continued from page 79 them in for the residents. During an interview with the Director of Food Service on March 29, 2023, at 9:57 AM, she revealed that they are only able to stock and offer evening snacks due to budgetary restrictions. She also revealed that they do not stock the nursing unit pantries based on par levels, but instead send a bag of miscellaneous snacks to the units on the dinner carts. During a later interview with the Director of Food Service on March 29, 2023, at 12:20 PM, she revealed that the facility is only able to purchase a limited amount of snacks due to budgetary constraints. A tour of the kitchen dry storage with the Director of Food Service at that time revealed chips, graham crackers, oatmeal pies, fudge rounds, Nilla wafers, and some peanut butter crackers. She stated that she would not consider these items to be a substantial snack. She also revealed that residents on an altered texture diet (pureed) would be provided with applesauce as a snack.	F 0809		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395016	A. BLDG: __00_____ B. WING: _____	03/30/2023

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F 0809 SS=E	Continued from page 80 When informed of the aforementioned concern on March 30, 2023, at 1:25 PM, the Nursing Home Administrator did not provide any additional information. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.6(b) Dietary services	F 0809		
F 0842 SS=E		F 0842		

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F 0842 SS=E	Continued from page 81 483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 0842	1. R55 was not negatively affected by this concern. 2. Facility will conduct audit of MARS and TARS for last 30 days to ensure no other residents were affected by this concern. 3. Re-education will be provided to nursing staff regarding importance of documentation to MARS/TARS and Point of Care. Clinical meeting process revised to ensure review of missing documentation during clinical meeting. 4. DON/designee will audit 10 residents weekly for missing documentation in MARS/TARS; then 10 monthly x2 months. Audits will be brought to QAPI to ensure compliance and quality improvement.	Completion Date: **05/16/2023** Status: **APPROVED** Date: **04/14/2023**

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F 0842 SS=E	Continued from page 82 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 0842		

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F 0842 SS=E	Continued from page 83 This REQUIREMENT is not met as evidenced by:	F 0842		

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F 0842 SS=E	Continued from page 84 Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that residents' medical records were complete and accurately documented for one of 22 residents reviewed (Resident 55). Findings include: Review of Resident 55's clinical record revealed diagnoses that included anemia (condition that develops when the blood lacks enough healthy red blood cells) and pressure ulcer of left buttock (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result or pressure, or pressure in combination with shear and/or friction). Review of Resident 55's March 2023 TAR (Treatment Administration Record - form used to document physician orders as well as when and how treatments are administered to a resident) revealed the following orders were not documented as being completed on the dates noted: calcium alginate/foam	F 0842		

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F 0842 SS=E	Continued from page 85 dressing to right hip daily (not documented as completed on March 8, 17, and 27, 2023); flush foley catheter with normal saline every day shift to prevent blockage (not documented on March 17 and 27, 2023); cleanse right buttocks and right upper thigh wounds with normal saline then apply Xeroform and foam dressing daily (not documented on March 8, 17, and 27, 2023); and Calmoseptine paste to left buttocks and thigh twice a day (not documented on day shift March 8, 17, and 27, 2023). During an interview with the Assistant Director of Nursing on March 30, 2023, at 12:07 PM, she revealed that she was able to confirm with the nurse that all wound care was completed, but did not know why it was not documented. During an interview with the Director of Nursing on March 30, 2023, at approximately 12:30 PM, she revealed she had no additional information regarding the aforementioned missing foley catheter care documentation.	F 0842		

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F 0842 SS=E	Continued from page 86 28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0842		
F 0909 SS=D	483.90(d)(3) Resident Bed §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by:	F 0909	1. R16, R39, and R55 beds were measured with no concerns noted. Rails fit appropriately. 2. Audit of all residents with enabler bar was conducted with no additional concerns noted. 3. Education will be completed with maintenance staff on policy for bed, mattress, and rail inspections. Education to include process for quarterly inspections of enabler bars. 4. Maintenance Director/designee will audit 5 enabler bars weekly x 4 weeks, then up to 10 monthly x2 months to ensure compliance with measurements. Audits will be brought to QAPI to ensure compliance and quality improvement.	Completion Date: **05/16/2023** Status: **APPROVED** Date: **04/14/2023**

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F 0909 SS=D	Continued from page 87 Based on observation, record review, and staff interview, it was determined that the facility failed to conduct regular inspections of bed rails/enabler bars to identify areas of possible entrapment for three of 22 residents reviewed (Residents 16, 39, and 55). Findings include: Review of Resident 16's clinical record included muscle weakness (when your full effort doesn't produce a normal muscle contraction or movement) and diabetes mellitus (a disease characterized by high blood glucose). Observation of Resident 16's bed on March 28, 2023, at 11:30 AM, revealed the presence of a 1/2 side rails on the Resident's bed. Review of facility provided records failed to reveal any regular inspections or measurements to ensure that the rails fit correctly. Review of Resident 39's clinical record revealed	F 0909		

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F 0909 SS=D	Continued from page 88 diagnosis of type 2 diabetes (a chronic condition that affects the way the body processes blood sugar) and chronic kidney disease (longstanding disease of the kidneys leading to renal failure). Observation of Resident 39's bed on March 29, 2023, at 1:20 PM, revealed the presence of a 1/2 side rails on the Resident's bed. Review of Resident 55's clinical record revealed diagnoses that included morbid obesity (serious health condition that results from an abnormally high body mass) and difficulty in walking. Observation on March 27, 2023, at 10:17 AM, revealed bilateral enablers were present on Resident 55's bed. Review of facility provided records failed to reveal any regular inspections or measurements to ensure that the rails fit correctly. During an interview with the Nursing Home	F 0909		

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F 0909 SS=D	Continued from page 89 Administrator on March 30, 2023, at 11:36 AM, she confirmed that, during staff turnover in the summer of 2022, the staff member previously assigned to track enabler bar/mattress measurements discarded them. The new employee in that position was unaware of the responsibility, so measurements have not been completed since that time. 28 PA code 201.18(b)(1)(e)(1) Management	F 0909		
F 0947 SS=E		F 0947		

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F 0947 SS=E	Continued from page 90 483.95(g)(1)-(4) Required In-Service Training for Nurse Aides §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by:	F 0947	1. No residents were negatively affected by this concern. 2. Facility had identified need for additional nurse aide training and will ensure ongoing training. 3. Facility will develop monthly education in-services program to ensure compliance with this regulation. In-services will be offered monthly and mandatory for nurse aides. 4. HR/DON designee will conduct audits of monthly in-services to ensure nurse aide attendance for continuing education credit. Audits will be brought to QAPI to ensure compliance and quality improvement.	Completion Date: **05/16/2023** Status: **APPROVED** Date: **04/14/2023**

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F 0947 SS=E	Continued from page 91 Based on document review and staff interview, it was determined that the facility failed to ensure nurse aides receive the required in-service training to ensure continuing competence and be no less than 12 hours per year for five of five nurse aide staff training information requested (Employees 4, 5, 6, 7, and 8). Findings Include: Review of requested training information to include hours and course content for five nurse aides (Employees 4, 5, 6, 7, and 8), revealed the facility could not produce any documentation of yearly in-service training to ensure continuing employee competence. An interview with the Nursing Home Administrator on March 29, 2023, at 11:38 AM, revealed the facility had no documents to support yearly in-service training for the aforementioned nurse aide staff.	F 0947		

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F 0947 SS=E	Continued from page 92 28 Pa. Code 201.18 (b) (1) Management 28 Pa. Code 201.20 (a) (c) (d) Staff development	F 0947		

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P 0400	§ 201.14(a) Responsibility of licensee. (a) The licensee is responsible for meeting the minimum standards for the operation of a facility as set forth by the Department and by other State and local agencies responsible for the health and welfare of residents. This REGULATION is not met as evidenced by:	P 0400	1. No residents were negatively affected by this concern. 2. Audit revealed that pharmacy and lab personnel not in attendance consistently with quarterly meetings. 3. Education will be provided to Infection Control Nurse, along with committee members to reinforce importance of quarterly attendance to meeting. 4. Infection Control Nurse/designee will conduct audits of quarterly infection control meetings to ensure all required members are in attendance. Audits will be brought to QAPI to ensure compliance and quality improvement.	Completion Date: **05/16/2023** Status: **APPROVED** Date: **04/14/2023**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE:	(X6) DATE:

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P 0400	Continued from page 1 Based on an interview and review of the facility's Infection Control Meeting attendance record, the facility failed to ensure that two of the required nine multidisciplinary members were present at the Infection Control meetings (laboratory personnel and a pharmacy personnel). Findings include: Review of Act 52 (The Act of March 20, 2002, P.L.154, No. 13), known as the Medical Care Availability and Reduction of Error (Mcare) Act, Chapter 4, Section 403(1) Infection Control plan states, "A health care facility... shall develop and implement an internal infection control plan that shall include...a multidisciplinary committee including representatives from each of the following if applicable to that specific health care facility." A review of the applicable members includes Medical Staff, Administration, Nursing Staff, Patient Safety Officer, Physical Plant Personnel, a community member, laboratory personnel,	P 0400		

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P 0400	Continued from page 2 pharmacy staff, and infection control team members. Review of facility provided Infection Control Committee Attendee signature pages failed to reveal that laboratory staff and pharmacy personnel were in attendance. An interview with the Director of Nursing on March 30, 2023, at 11:30 AM, revealed that the facility did not have laboratory staff or pharmacy staff in attendance at the meetings.	P 0400		
P 2020		P 2020		

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HANOVER HALL FOR NURSING AND REHABILITATION STATE LICENSE NUMBER: **590102**	**267 FREDERICK STREET HANOVER, PA 17331**

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P 2020	Continued from page 3 § 211.12(i) Nursing services. (i) A minimum number of general nursing care hours shall be provided for each 24-hour period. The total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 2.7 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 2020	1. Facility cannot retroactively correct this concern. 2. Audit of grievance log for the days the facility did not meet PPD was reviewed. No concerns noted on these days. 3. Facility will continue efforts of recruiting. Facility will monitor PPD daily to ensure appropriate levels of care being met. 4. NHA/designee will review grievance log weekly x4 weeks; then monthly x2 months to ensure there are no care concerns affiliated with staffing levels. Audits will be reviewed at QAPI to ensure compliance and quality improvement.	Completion Date: **05/16/2023** Status: **APPROVED** Date: **04/14/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395016	A. BLDG: 00 B. WING:	03/30/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HANOVER HALL FOR NURSING AND REHABILITATION STATE LICENSE NUMBER: **590102**	**267 FREDERICK STREET HANOVER, PA 17331**

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P 2020	Continued from page 4 Based on document review and staff interview, it was determined that the facility failed to ensure a minimum number of general nursing care hours provided in a 24 hour period shall be 2.70 hours of direct resident care for three days of one week of nursing care hours reviewed (March 12, 17, and 18, 2023). Findings Include: Review of the nursing care hours provided by the Nursing Home Administrator (NHA) on March 29, 2023, revealed the total number of nursing care hours provided on March 12, 2023, to be 2.66. The total number of hours provided on March 17, 2023, were documented as 2.34 hours. The total number of hours provided on March 18, 2023, were documented as 2.69. An interview with the NHA on March 29, 2023, revealed an acknowledgement that the facility failed to meet the required minimum of 2.70 hours of direct resident care on those dates reviewed.	P 2020		

Certified End Page

HANOVER HALL FOR NURSING AND REHABILITATION

STATE LICENSE NUMBER: 590102

SURVEY EXIT DATE: 03/30/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY